

## **Introduction: Inside the Specialized Inpatient PTSD Units of the Department of Veterans Affairs**

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Specialized Inpatient PTSD Units (SIPUs), created during the 1980s by the Department of Veterans Affairs to treat combat-related posttraumatic stress disorder (PTSD), represent a unique and unprecedented effort by a government to respond to the psychiatric needs of returning soldiers. Begun in the midst of professional enthusiasm over the introduction of the PTSD diagnosis into psychiatric nomenclature, and stimulated by a decade of advocacy by the veterans themselves, the SIPU became the flagship of a concentrated psychotherapeutic effort to reduce suffering as well as to redress the lack of attention previously given to the Vietnam veteran.

The SIPU models, despite wide variation in details, offered a broadly consistent treatment regimen: long length of stay (>90 days), intensive group and individual treatments based on reviewing the veterans' traumatic experiences, and rehabilitative, family, and milieu therapies. With few exceptions, the atmospheres of these units were characterized by excitement, challenge, and even missionary zeal, as therapists listened to the stories of the veterans, and veterans appreciated the special care they were at last receiving.

As outcome data became available during the early 1990s, and as better designed and controlled studies continue to confirm, the field has reluctantly discovered that the SIPUs have not produced significant or sustained improvement in the veterans' PTSD symptoms, especially at follow-up points 4 to 12 months after discharge (Fontana & Rosenheck, in press; Johnson et al., 1996; Perconte, 1989; Scurfield, Kenderdine, & Pollard, 1990; Shalev, Bonne, & Eth, 1996). Despite wide veteran and staff

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satisfaction with and commitment to these programs, the benefits appear to be modest at best. These results occur within a context of longstanding persistence of PTSD symptoms in the general population as a whole (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Thus, in 1996, the Department of Veterans Affairs began a process of shifting resources from the SIPU to outpatient and day treatment programs.

The three empirical papers in this Special Section do not address outcome directly, but rather examine internal aspects of the SIPU in order to illuminate processes that may or may not help to explain the disappointing outcome data. Though focused on combat-related PTSD, the methodologies employed are potentially applicable to a wide range of PTSD treatment programs, and hopefully may contribute to a more detailed study of treatment efficacy and process in general. The results reported in this Section are highly tentative due to significant limitations in the design and scope of these studies; they should be viewed as only suggestive of more specific hypotheses and hopefully more rigorous empirical inquiry. Nevertheless, the questions raised by these papers are hard ones, and the possible answers to those questions will require a steadfast loyalty to data rather than desire, and an ability to tolerate disappointment without becoming disillusioned.

The first paper, "Assessing the Structure, Content, and Perceived Social Climate of Residential PTSD Treatment Programs," attempted to determine whether the SIPU can indeed be differentiated from general psychiatric units (GPU), in terms of the dimensions of structure, content, and perceived social climate. The authors polled 19 SIPUs and 18 GPUs across the country and found significant differences between program types. The SIPUs, in comparison to the GPUs, were more clearly differentiated from the larger hospital system, had more strict patient selection criteria and program regulations, longer length of stays, spent more time on PTSD and war zone experiences, and were perceived by the veterans as more supportive and better structured. The authors conclude that the SIPU's designation as "specialized" may indeed be justified, and therefore outcomes of these programs could be attributed to their unique design and treatment characteristics.

The second and third papers examined individual treatment components within one program in an attempt to develop a method of estimating their relative efficacy. The second paper, "Single Session Effects of Treatment Components within a Specialized Inpatient PTSD Program," measured the short-term effects of 15 treatment components on two cohorts of veterans, and found that components that focused the veterans on external rather than internal stimuli, used an action rather than verbal modality, and involved little Vietnam content, provided significantly greater sympto-

matic relief. These effects, however, were not correlated with veterans' ratings at discharge of the relative benefit of the treatment components. The study suggests that rehabilitative treatments may cause short-term decreases in distress, possibly through the process of distraction, while exposure-based treatments may cause short-term increases in distress. Importantly, the study's methodology was able to detect these differences between specific treatment components within a complex and multimodal therapeutic program. The study did not address whether these short-term effects predicted long-term outcome.

The third paper, "Treatment Preferences of Vietnam Veterans with Posttraumatic Stress Disorder," examined shifts in the veterans' ratings of benefit of each treatment component over time, from discharge to 4-month and 12-month follow-up, to discover whether any general trends were identifiable. The authors discovered that by 4 months after discharge the veterans had shifted their rankings of greatest benefit toward the same cluster of components as identified in the second paper: little Vietnam content, behavioral and educative formats, external focus, and action modality. The authors note that this cluster corresponds to a rehabilitative rather than a psychotherapeutic (i.e., introspective, exposure-based) treatment approach. These results were even more significant among veterans with higher levels of PTSD symptomatology, suggesting that a rehabilitative focus may be most beneficial for chronically ill veterans with PTSD.

The Special Section concludes with thoughtful commentaries by Robert Rosenheck, Alan Fontana, and Paul Errera from the perspective of the Department of Veterans Affairs, and by Arie Shalev from the perspective of the larger PTSD field.

Collectively, these papers raise the question whether, for combat veterans with PTSD, the intensive examination of war and traumatic experience within the SIPU is beneficial. Trauma therapists, including this writer, have long held to the notion that it is essential to have the patient express and explore his/her traumatic experience, even when that trauma occurred many years before, as is the case with the Vietnam veteran. Yet, perhaps this principle is less applicable, even not true, for patients whose traumatic experience has been transformed into a chronic illness, having been integrated into the broader regions of personality and behavior. Nevertheless, this realization, so difficult to accept—and still not proven—is less an indictment of the SIPU than a recognition of the strength and persistence of the disorder. It should not weaken our resolve but harden us with an even greater commitment to treat PTSD as completely and in as timely a manner as possible.

### References

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